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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 18 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 34750

Registrar's No. 8716

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether)
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4300 St. Ferdinand
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Anna Talley

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex Female

5. Color or race Col

6. (a) Single, widowed, divorced Widowed

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased May (Month) 12 (Day) 1902 (Year)

8. AGE: Years 46 | Months 4 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Sedalia Missouri (City, town, or county) U (State or foreign country)

10. Usual occupation Maid

11. Industry or business ____

MOTHER FATHER

12. Name John Green

13. Birthplace ____ (City, town, or county) U (State or foreign country)

14. Maiden name Mable Green

15. Birthplace ____ (City, town, or county) Mo (State or foreign country)

16. (a) Informant William Waters

(b) Address 4000 Page

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo

18. (a) Signature of funeral director Herman J. Smith

(b) Address 4247 Labadie ave

19. (a) OCT 6 1948 (Date received local registrar) (b) J. B. Foster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5 year 1948 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Oct. 3, 1948 to Oct. 5, 1948 that I last saw her alive on Oct. 5, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intestinal Obstruction; Peritonitis	
Due to ____	
Due to ____	
Other conditions None (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations ____
Of autopsy Yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Charles K Frazer (M. D. or other)
Address 2601 N Whittier Date signed 10/5/48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 4341

P. O. Address Ithaca 13 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.